Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTER
PO BOX 24809
HOUSTON TX 77029

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-3094-01

MFDR Date Received
MAY 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon further review we have noted that the correct pre authorization number has been located in the appropriate box on the cms-1500 since it's initial faxing on 6/16/10."

Amount in Dispute: $106.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this matter, Requestor billed for an office visit under CPT code 99213. On their HCFA-1500, they listed in box 23 that the preauthorization approval number was 52952. However, preauthorization approval number 52952 allowed for physical therapy, not an office visit. Thus, the medical bill for the office visit was denied for lack of preauthorization as it was not covered under the preauthorization approval number alleged by the provider. No reimbursement should be allowed."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2010	Office Visit – CPT Code 99213-25	$106.00	$99.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 39-Services denied at the time authorization/pre-certification was requested.
   - W1-Workers Compensation state fee schedule adjustment.
   - Z306-Siginificant, separately identifiable evaluation and management service by the same Physician on the day of a procedure.

Issues

1. Did the disputed office visit, CPT code 99213-25, require preauthorization?
2. Does the documentation support a surgical procedure was performed on the disputed date of service?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed office visit, based upon reason code "39."

   28 Texas Administrative Code §134.600(p) does not list office visits as a health care that requires preauthorization; therefore, the insurance carrier's denial based upon reason code "39" is not supported.

2. The insurance carrier denied reimbursement for the disputed office visit based upon reason code "Z306."

   The respondent did not submit documentation to support that a procedure was done on the same day as the office visit; therefore, the insurance carrier's denial based upon reason code "Z306" is not supported.

3. Per 28 Texas Administrative Code §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.0791

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77090, which is located in Harris County.

   The Medicare participating amount for code 99213 in Harris County is $66.31.

   Using the above formula, the MAR is $99.84.

   The respondent paid $0.00. The requestor is due $99.84 additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $99.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $99.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/11/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.